



California Workers' Compensation Institute

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January 15, 2019

VIA E-MAIL – DWCForums@dir.ca.gov

Maureen Gray, Regulations Coordinator
Division of Workers' Compensation, Legal Unit
P.O. Box 420603
San Francisco, CA 94142

Re: Forum Comment - Draft MPN, Physician Reporting, UR, and IMR Regulatory Amendments

Dear Ms. Gray:

On behalf of its members, California Workers' Compensation Institute offers these comments on the Division's draft physician reporting and utilization review regulatory amendments. The Institute members include insurers writing 81% of California's workers' compensation premium, and self-insured employers with \$69.8B of annual payroll (31.5% of the state's total annual self-insured payroll).

Insurer members of the Institute include AIG, Alaska National Insurance Company, Allianz Global Corporate and Specialty, AmTrust North America, Berkshire Hathaway, CHUBB, CNA, CompWest Insurance Company, Crum & Forster, EMPLOYERS, Everest National Insurance Company, The Hartford, ICW Group, Liberty Mutual Insurance, Pacific Compensation Insurance Company, Preferred Employers Insurance, Republic Indemnity Company of America, Sentry Insurance, State Compensation Insurance Fund, Travelers, XL America, Zenith Insurance Company, and Zurich North America.

Self-insured employer members include Adventist Health, Albertsons/Safeway, BETA Healthcare Group, California Joint Powers Insurance Authority, California State University Risk Management Authority, Chevron Corporation, City and County of San Francisco, City of Los Angeles, City of Pasadena, City of Torrance, Contra Costa County Risk Management, Contra Costa County Schools Insurance Group, Costco Wholesale, County of Alameda, County of Los Angeles, County of San Bernardino Risk Management, County of Santa Clara Risk Management, Dignity Health, Foster Farms, Grimmway Farms, Kaiser Permanente, Marriott International, Inc., North Bay Schools Insurance Authority, Pacific Gas & Electric Company, Schools Insurance Authority, Sempra Energy, Shasta County Risk Management, Shasta-Trinity Schools Insurance Group, Southern California Edison, Special District Risk Management Authority, Sutter Health, University of California, and The Walt Disney Company.

The Institute recognizes that the Division's task in amending these regulations is far from simple and supports the Division's decision to start via Forum. At this juncture, the Institute would like to offer the following bulleted comments for consideration.

Where specific text revisions are recommended, they are identified by underscore and ~~strikeout~~. Comments and discussion by the Institute are identified by *italicized text*.

Priority Considerations

- A primary objective of SB 1160 was to reduce the number of UR events by providing more expeditious treatment with a corresponding reduction in the administrative burden. The Institute urges the Division to focus on these goals as the rulemaking process continues.
- As regulation sections 9792.6.1(u) and 9785 (g) are currently drafted, a request for authorization is allowed via narrative report. Without a required form, claims administrators are going to have a much more difficult time triaging what is and what isn't a request for authorization in an expeditious manner which could cause delays in treatment. If the narrative request for authorization option is to remain, the Institute recommends that language be mandated at the top of the narrative report stating, "Request for Authorization" in bold font.
- Our interpretation of the proposed regulation section 9792.9.7(a) is that a written request for authorization is required for all services, even if it is not subject to prospective review. This would be in conflict with the goal of reducing the administrative burden associated with pass-through and other services. Clarification is needed concerning when a request for authorization is required
- Labor Code section 4610(i)(1) requires that prospective or concurrent UR decisions be made within "five working days," and the Institute applauds the Division's inclusion of definitions for "working days" and "business days" in the new UR regulations. To maintain statutory consistency with section 4610(i)(1), however, all UR timeframe regulations should reference "working days" as opposed to "business days," with two exceptions:
 1. Availability of UR services under section 4600.4 (specifically referencing "each normal business day"); and
 2. Deadline for communicating a prospective UR decision under section 4610(i)(4)(B) (specifically referencing "two business days").
- In light of the evolving role of non-primary treatment providers, the interests of the injured worker are best supported by application of appropriate rules to all providers of medical treatment. Application of rules to all treatment providers comports with current practices, and is consistent with Labor Code sections 4610(f)(2) and 4610.5(c)(3). Accordingly, the Institute recommends revision of Article 5 (TITLE) and Labor Code section 9785 to clearly differentiate the responsibilities of the Primary Treating Physician, while also confirming the requirements of any treating physician, *vis-à-vis* requests for authorization, prescribing drug treatment and/or providing pass-through treatment.
- Labor Code 4610(f) gives employers and insurers the exclusive right to determine members of their MPNs. Proposed sections 9792.9.7(c) and (d) would contradict the statute, at least in part, by creating specific requirements for removal of a provider from an MPN and by vesting jurisdiction with the WCAB for any resulting dispute. Each of these provisions represents an invalid infringement on the employer's and insurer's rights under Labor Code section 4610(f).

Summary of General Recommendations

- Use of email for submitting requests for authorization and other sensitive communications (with respect to content or time) should only be permitted with prior agreement of the parties.
- References to “physical address” should be changed to “mailing address.”
- Despite the statutory mandate of Labor Code section 6409(a), CCR section 9785(e) makes no reference to electronic submission of the Doctor’s First Report (Form 5021).
- CCR section 9786 is internally inconsistent, because subdivision (b)(6) defines “good cause” to grant a petition for a change in physician as including non-compliance with the MTUS, while (c)(2) prohibits that same non-compliance with appropriate medical treatment from serving as “good cause.” The Institute recommends deletion of conflicting language in (c)(2), in order to avoid confusion.
- Adoption of the proposed PR-1 report will require revisions to the Official Medical Fee Schedule for Physician and Non-Physician Practitioner Services (sections 9789.12.14 and 9789.14(b)(1)).
- The Division’s website URL reference to its home page listed in CCR section 9781(d)(7) is outdated. The Institute recommends that the provided URL be an address that is unlikely to change in the future, such as: <http://www.dir.ca.gov/dwc/>.
- The definition in CCR section 9792.6.1(n) “Material Modification” is too vague to be appropriately enforced. Since penalties are tied to failure to comply, this definition needs to be expressly stated.
- In section 9792.9.5(f), following a UR denial based on lack of information, there is no provision for the provider or the injured worker to submit the missing information, and there is no limitation on the time within which the additional information may be submitted.
- Sections 9792.9.7(a)(4) and 9792.6.1(u) incorrectly reference the requirements for an RFA “in accordance with” and “in the manner authorized by” section 9785(h); the references should be updated to section 9785(g), in order to reflect the renumbering of that section.
- The definition of “pattern and practice” as set forth in section 9792.9.7(c)(2) is too lenient, and should be re-defined to encourage provider compliance with the MTUS.

Comments Related to PR-1 Form:

- Under “Expedited Request for Authorization,” recommend adding “Imminent and serious threat to life or health” in order to conform with Labor Code section 4610(i)(3).
- Strongly recommend that the PR-1 be modified to make a “request for authorization” more obvious. Suggest adding a requirement that the number of services being requested be included along with the “request for authorization” label/check box. Suggest that all box choices related to a request for authorization be in bold font, sectioned off at the very top, with added wording to remind the requesting physician to complete the necessary sections to substantiate the request.
- Add a section requiring the requesting physician to provide specific reference to the MTUS, in order to encourage consideration of the MTUS.

- The present formatting does not provide enough space for each specific treatment request.
- RFAs often contain multiple treatment requests for the same date of service (especially related to surgery requests); the present formatting requires the provider to attach additional pages rather than providing separate rows for each request.
- The Division's concept of a multi-part form for treatment requests involving a call-and-response format across several entities is not practical from an operational standpoint. Inclusion of the physician's treatment request, claims administrator authorization, and URO response in a single document is not desirable; indeed, the UR determination contains much more information than is contemplated on page 4 of the PR-1 form. The Institute recommends that space be provided to identify what is being approved, and that the "response" section on page 4 be eliminated.

Comments Related to UR-01 Form:

- Add option to allow qualified public entities to indicate exemption from URAC accreditation if the requirements of section 9792.27(a)(6)(B) have been met.

Regulations: Medical Provider Network, Physician Reporting, Utilization Review and Independent Medical Review

Title 8, California Code of Regulations Division 1, Chapter 4.5 Division of Workers' Compensation Subchapter 1 Administrative Director – Administrative Rules

Recommendation:

Modify § 9767.6 (f) as follows:

(f) The insurer or employer shall deliver to the initial primary treating MPN physician selected by the employee all relevant medical records relating to the claim, including the results of diagnostic and laboratory testing done in relation to the injured employee's treatment. The insurer or employer shall advise any subsequently selected MPN physician that any medical record or diagnostic and laboratory test result deemed relevant to that provider will be delivered upon request. The insurer or employer shall also advise all selected MPN physicians of the name, telephone number, fax number, email address, if agreed by the parties in writing, and physical mailing address of the individual to whom a request for authorization should be sent.

Discussion:

The Institute recommends further consideration be given to the use of email as an accepted method of communication, particularly as it relates to HIPAA and other privacy concerns. In any circumstance, the Institute recommends that email submissions be permitted only upon written prior agreement by the parties, and only if submitted via secure email.

Replace "physical address" with "mailing address" because the physical address may differ from the address where the correspondence should be directed.

Recommendation:

Modify Article 5 TITLE, as follows:

Article 5. Predesignation of Personal Physician; Request for Change of Physician; Reporting Duties of the Primary Treating Physicians; Petition for Change of Primary Treating Physician

Discussion:

In light of the evolving role of non-primary treatment providers, the interests of the injured worker are best supported by application of appropriate rules to all providers of medical treatment.

Recommendation:

Modify § 9781(d)(5) as follows:

(5) Provide the physician or facility with the name, telephone number, fax number, email address, and physical mailing address of the individual to whom a request for authorization should be sent.

Discussion:

Replace “physical address” with “mailing address” for reasons previously delineated, and to maintain consistency.

Recommendation:

Modify § 9781(d)(7) as follows:

(7) Provide the physician or facility with (1) the complete requirements of section 9785; and (2) the required reporting forms under that section. In addition, the claims administrator shall refer the physician or facility to the Division of Workers’ Compensation’s website where the applicable information and forms can be found at http://www.dir.ca.gov/DWC/dwc_home_page.htm <https://www.dir.ca.gov/dwc/> or <https://www.dir.ca.gov/dwc/MedicalProvider.htm>.

Discussion:

The URL currently referenced is no longer active and needs to be updated to a URL that is unlikely to change. The URL <https://www.dir.ca.gov/dwc/MedicalProvider.htm> currently takes the provider to pertinent information, as well as a link to applicable forms. If, however, there is a possibility that this URL will change, the Division’s home page URL is recommended: <https://www.dir.ca.gov/dwc/>.

Recommendation:

Modify § 9785 to delete references to “primary” as follows:

§9785. Reporting Duties of ~~the Primary~~ Treating Physicians.

Discussion:

To maintain statutory and regulatory consistency, the Institute recommends deletion of “primary” as a qualifier in the title, and revision of the text of section 9785 to more fully address the respective obligations of each treating physician. Since section 9785 addresses both primary and secondary treating physicians (with subdivision (h) specifically stating that either may submit an RFA), it is inconsistent to limit reporting requirements to only the primary treating physician.

In light of the evolving role of non-Primary treating physicians, the interests of the injured worker are best supported by application of appropriate rules to all providers of medical treatment.

Recommendation:

Modify § 9785 (a) as follows:

(1) The “primary treating physician” is the physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter. The primary treating physician is the physician selected by the employer, the employee pursuant to Article 2 (commencing with section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code, or under the contract or procedures applicable to a Health Care Organization certified under section 4600.5 of the Labor Code, or in accordance with the physician selection procedures contained in the medical provider network pursuant to Labor Code section 4616. For injuries on or after January 1, 2004, a chiropractor shall not be a primary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized additional visits in writing. For purposes of this subdivision, the term “chiropractic visit” means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. This prohibition shall not apply to post-operative rehabilitation treatment pursuant to section 9792.24.3 the provision of postsurgical physical medicine that is prescribed by the employee’s surgeon, or physician designated by the surgeon, and is pursuant to in accordance with the postsurgical component of the medical treatment utilization schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27. For purposes of this subdivision, the term “chiropractic visit” means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.

(2) A “secondary physician” is any physician other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee. For injuries on or after January 1, 2004, a chiropractor shall not be a secondary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized, in writing, additional visits. For purposes of this subdivision, the term “chiropractic visit” means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation. This prohibition shall not apply to post-operative rehabilitation treatment pursuant to section 9792.24.3 the provision of postsurgical physical medicine that is prescribed by the employee’s surgeon, or physician designated by the surgeon, and is pursuant to in accordance with the postsurgical component of the medical treatment utilization schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27. For purposes of this subdivision, the term “chiropractic visit” means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.

Discussion:

To avoid confusion, CCR sections 9785(a)(1) and (2) should be rewritten to reflect the changes made to CCR section 9792.24.3 of the Medical Treatment Utilization Schedule regulations regarding post-surgical treatment.

Recommendation:

Modify § 9785 (d) as follows:

(d) The primary treating physician shall render opinions on all medical issues necessary to determine the employee’s eligibility for compensation in the manner prescribed in subdivisions (e), (f), (g), and (i), and (j) of this section. The primary treating physician may transmit reports to the claims administrator by mail or FAX or by any other means satisfactory to the claims administrator, including electronic transmission.

Discussion:

Each of the identified subdivisions reference compensation; omission of subdivision (j) appears to have been an oversight.

Recommendation:

Modify § 9785 (f)(2) as follows:

(2) There is any significant change in the treatment plan reported, including, but not limited to, (A) an extension of duration or frequency of treatment, (B) a new need for hospitalization or surgery, (C) a new need for referral to a secondary physician for treatment or consultation ~~by another physician~~, (D) a change in methods of treatment or in required physical medicine services, or (E) a need for rental or purchase of durable medical equipment or orthotic devices;

Discussion:

Deletion of language in subdivision (2)(C) will improve syntax while maintaining substance.

Recommendation:

(g) (5) Any treating physician who renders drug treatment pursuant to CCR section 9792.27.3 shall provide the report mandated by subdivision (b)(2) of that section.

Discussion:

In order to ensure that prescribing physicians either conform to, or justify treatment outside of, the MTUS Drug Formulary, the Institute recommends that the 9785 requirement letter specifically reference the reporting mandate of section 9792.27.3(b)(2), and that the mandate apply to any prescribing physician. While some injured workers will be maintained on long-term opioid and/or psychotropic therapy, it is nevertheless incumbent upon the prescribing physician to attempt to taper these medications in accordance with the guidelines, or to justify continuing drug treatment outside the MTUS Drug Formulary. Since the claims administrator is mandated to not abruptly discontinue continuing drug treatment on legacy claims, the regulations need to address this type of problem so that no prescribing physician is allowed to ignore the MTUS Drug Formulary to the detriment of the injured worker.

Recommendation:

Modify § 9785(j) as follows:

(j) The primary treating physician, upon finding that the employee is permanent and stationary as to all conditions and that the injury has resulted in permanent partial disability, shall complete the “Physician’s Return-to-Work & Voucher Report” (DWC-AD 10133.36) and attach the form to the report required under subdivision (h).

Discussion:

Because the subdivisions have been renumbered, the reference to (h) in section 9785(j) needs to be corrected.

Recommendation & Discussion: § 9785.6 Treating Physician's Report (DWC Form PR-1):

Because both primary and secondary physicians will be using the PR-1 form, the Institute recommends that the form include restrictions based on the role of the submitting physician. The options to comment on Release from Care and Change in Work Status should be limited to the designated Primary Treating Physician. Otherwise, the potential for conflicting determinations as between treatment providers will increase disputes and litigation.

Adoption of the proposed PR-1 report will require revisions to the Official Medical Fee Schedule for Physician and Non-Physician Practitioner Services (sections 9789.12.14 and 9789.14(b)(1)).

Recommendation:

Modify § 9786(c)(2) as follows:

(2) Good cause shall not include a showing that ~~current treatment is inappropriate or that~~ there is no present need for medical treatment to cure or relieve from the effects of the injury or illness.

Discussion:

The language recommended for deletion in § 9786 (c)(2) is in direct conflict with the provisions of (b)(6), and should be deleted.

Recommendation:

Modify § 9786(c)(3) as follows:

(3) Where an allegation of good cause is based upon failure to timely issue the “Doctor’s First Report of Occupational Injury or Illness,” Form ~~DLSR~~ 5021, within 5 working days of the initial examination pursuant to Section 9785, subdivision (e)(1) ~~or (e)(2)~~, the petition setting forth such allegation shall be filed within 90 days of the **claims administrator’s knowledge** of the initial examination.

Discussion:

Clarifying language is recommended in order to avoid a loophole where the claims administrator is unaware of the examination itself.

*Most references to “primary” treating physician in section 9786 should be deleted. Given that Labor Code sections 4603 and 4610(f)(2) do not qualify the physician as **primary**, the Division should consider revising 9786, as well as 9786.1 (and the form), in a way that maintains statutory consistency and recognizes the potential need for change of treating physician who is not primary.*

Recommendation:

Delete § 9792.5(f)(1)(I):

~~(I) A statement that if the claims administrator's internal utilization review appeals process fails to resolve the dispute regarding the necessity of the requested information, or whether the requested information was previously available to the claims administrator, the injured worker may seek resolution of the dispute by filing a petition for determination of medical treatment dispute with the Workers' Compensation Appeals Board under California Code of Regulations, title 8, section 10451.2, subdivision (c).~~

Discussion:

Inclusion of this subdivision represents an improper expansion of WCAB jurisdiction. The Courts of Appeal have, in numerous published decisions, confirmed the principles stated in Dubon II that a dispute related to the timeliness of a UR determination falls under the jurisdiction of the WCAB, but all other disputes related to medical necessity fall within the IMR process.

Recommendation:

Modify § 9792.6.1 (m) as follows:

(m) “Immediately” means within one **businessworking** day.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to “business days” in the regulations should be changed to “working days” in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.6.1 (n) as follows:

(n) “Material modification” ~~includes but is not limited to a change in the plan’s operations or contracts impacting utilization review is such as~~ when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.

Discussion:

The definition of “Material modification” is overly broad and vague; since penalties are tied to non-compliance, this definition needs to be stated in express terms. The Institute recommends reverting to the original language of the regulation.

Recommendation:

Modify § 9792.6.1(u)(1) as follows:

(1) Unless accepted by a claims administrator under section 9792.9.1(b), a request for authorization must be completed by the treating physician in the manner authorized by section 9785(hg).

Discussion:

The correct reference here is to § 9785(g), not (h), due to new renumbering of that section.

Recommendation:

Modify § 9792.6.1(u)(2) as follows:

(2) “~~Completed or completed~~,” for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization:

(A) identifies both the employee and the requesting provider;
(B) identifies with specificity all ~~the recommended requested~~ treatments in the designated section for requests for authorization if a form is used, or, on the first page if a narrative report is used; ~~and~~
(C) is accompanied by documentation, ~~issued or created no later than 30 days before the date of the request for authorization, that includes a progress report for an evaluation date no earlier than 30 days prior to the date of a request for authorization which substantiates~~ substantiating the need for the requested treatment. A request for authorization may be deemed completed following receipt of information, test results, or a specialized consultation requested under section 9792.9.1(f); ~~and~~
(D) is signed by the treating physician. By agreement of the parties, the treating physician may submit the request for authorization with an electronic or digital signature.

Discussion:

This section has been subdivided for purposes of clarity.

The recommended revision in new subdivision 2(C) restricts the time frame to ensure that requests for treatment are intended for the injured workers' most current needs. The 30-day time frame should not apply to all documentation since there may be relevant supporting documentation (e.g., an MRI report) that is older than 30 days.

Recommendation:

Modify § 9792.6.1(u)(3) as follows:

(3) The request for authorization ~~must be signed by the treating physician and~~ may be mailed, faxed, or sent electronically through the use of a secure, encrypted email system to the address, fax number, or e-mail address designated by the claims administrator under section 9781(d)(5) for this purpose. ~~By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.~~

Discussion:

The deletion of language in the first sentence corrects syntax. The final sentence has been moved to the definition of "completed" in subdivision (u)(2)(D), above.

Recommendation:

Modify § 9792.6.1(cc) as follows:

~~(cc) "Business day" is any day other than a Sunday, a day declared by the Governor to be an official State holiday, or a day listed at Calhr.ca.gov. "Working day" means any business day other than a Saturday. "Working day" means any day other than a Saturday, Sunday, or a day declared by the Governor to be an official State holiday. "Business day" shall not include January 1, the third Monday in January, the third Monday in February, March 31, the last Monday in May, July 4, the first Monday in September, November 11, Thanksgiving Day, the day after Thanksgiving, and December 25.~~

Discussion:

The Institute wholeheartedly supports the Division's intent to remove Saturdays from the definition of "working days." The suggested language is a simplified version that allows for future flexibility (i.e., holidays that may change over time). Because the website includes all of the Division's listed holidays and further because it is stated in the alternative to a Governor declaration, the proposed language will exclude Saturdays as well as all present and future State holidays from the definition of "working days."

Recommendation:

Modify § 9792.7 (a) as follows:

(a) Every claims administrator shall establish and maintain a utilization review process for **the determination of medical necessity of requested medically necessary** treatment in compliance with Labor Code section 4610. Each utilization review process shall be set forth in a utilization review plan which shall contain:

Discussion:

Additional language is added to §9792.7(a) to correct syntax.

Recommendation:

Modify § 9792.7 (b) as follows:

The following medical treatment services, unless **previously** authorized by the claims administrator or rendered as emergency medical treatment, cannot be provided under subdivision (a) and shall require prospective utilization review under section 9792.9.1 or 9792.9.3:

Discussion:

The recommended deletion maintains statutory consistency with Labor Code section 4610 (c)

Recommendation:

Modify 9792.7 (c) as follows:

(c) (1) The complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process, shall be filed by the claims administrator, or by the external utilization review organization contracted by the claims administrator to perform the utilization review, with the Administrative Director. In lieu of filing the utilization review plan, the claims administrator may submit a letter identifying the external utilization review organization which has been contracted to perform the utilization review functions, provided that the utilization review organization has filed a complete utilization review plan with the Administrative Director. A change in the information contained or which would be contained in the DWC Form UR-01, Application for Approval as a UR Plan, shall be filed with the Administrative Director within 30 calendar days after the modification is made. Notice **of a** to the Division of Workers' Compensation of a material modification, as defined at section 9792.6.1(n), shall be made in writing twenty (20) calendar days prior to the implementation of the material modification. The notice of material modification shall include a statement certifying that the utilization review plan, as modified, continues to be in compliance with the rules governing utilization review at sections 9792.6.1 et seq.

Discussion:

Language is deleted from subdivision (c)(1) to correct syntax.

Recommendation:

Modify 9792.7(g)(3) as follows:

(3) The Administrative Director shall post on the Division's website a list of all entities who have filed a complete utilization review plan under this section, indicating ~~the which~~ plans ~~have been~~ approved under subdivision (e).

Discussion:

Additional language is added to §9792.7(g)(3) to correct syntax.

Recommendation:

Modify § 9792.9.1(a)(1), as follows:

For purposes of this section, a request for authorization ~~the DWC Form RFA~~ shall be deemed to have been received by the claims administrator or its utilization review organization by facsimile or by electronic mail on the date the form was received if the receiving facsimile or electronic mail address electronically date stamps the transmission when received. If there is no electronically stamped date recorded, then the date the form was transmitted shall be deemed to be the date the form was received by the claims administrator or the claims administrator's utilization review organization. A request for authorization ~~the DWC Form RFA~~ transmitted by facsimile after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day working day, except in the case of an expedited or concurrent review. The copy of the request for authorization or the cover sheet accompanying the form transmitted by a facsimile transmission or by electronic mail shall bear a notation of the date, time and place of transmission and the facsimile telephone number or the electronic mail address to which the form was transmitted or the form shall be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax or electronic mail transmission report, which shall display the facsimile telephone number to which the form was transmitted. The requesting physician must indicate if there is the need for an expedited review on the request for authorization.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to "business days" in the regulations should be changed to "working days" in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.9.1(a)(2)(A):

Where the request for authorization ~~DWC Form RFA~~ is sent by mail and the place of address and the place of mailing is within the State of California, the form, absent documentation of receipt, shall be deemed to have been received by the claims administrator five (5) business calendar days after the deposit in the mail at a facility regularly maintained by the United States Postal Service.

Discussion:

*A change of “business days” to “working days” in this instance is **not** recommended, as the computation of time for presumed receipt of a mailed document is wholly different from computation of whether a utilization review determination is timely. The “mailbox rule” is borrowed from Code of Civil Procedure section 1013, and the Institute accordingly recommends the use of “calendar days” instead of “business days” in order to maintain consistency with well-established rules for mailed documents. However, as with CCP § 1013, the five-day presumption should apply only to intra-state mail; the Institute urges the Division to consider adoption of language similar to CCP § 1013 as it relates to out-of-state mailings.*

Recommendation:

Do not change “business days” in 9792.9.1(a)(3):

(3) Every claims administrator shall maintain telephone access and have a representative personally available by telephone from 9:00 AM to 5:30 PM Pacific Time, on business days for health care providers to request authorization for medical services. Every claims administrator shall have a facsimile number available for physicians to request authorization for medical services. Every claims administrator shall maintain a process to receive communications from health care providers requesting authorization for medical services after business hours. For purposes of this section the requirement that the claims administrator maintain a process to receive communications from requesting physicians after business hours shall be satisfied by maintaining a voice mail system or a facsimile number or a designated email address for after business hours requests.

Discussion:

*To promote consistency with Labor Code section 4600.4, “business days” in this instance is **not** recommended to be replaced with “working days.” The issue of maintaining access (for providers to request authorization for medical services) is wholly different from how to count days in determining whether a utilization review determination is timely. Indeed, in the case of an expedited review where there is an imminent and serious threat to the health of an employee, this availability of access is crucial.*

Recommendation:

Modify § 9792.9.1(b) as follows:

(b) Upon receipt of a request for authorization that does not meet the definition of a complete request for authorization under section 9792.6.1(u), a non-physician reviewer as allowed by section 9792.7 or physician reviewer must either accept the request as a complete request for authorization and comply with the requirements in this article or mark it “not complete” and return it to the requesting physician, specifying the reasons for the return of the request, no later than five (5) ~~business days~~**working days** from receipt. A request for authorization accepted as complete shall be subject to investigation under section 9792.11 and the assessment of administrative penalties under section 9792.12.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to “business days” in the regulations should be changed to “working days” in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.9.2(b) as follows:

(b) If the claims administrator disputes liability under this subdivision, it may, no later than five (5) ~~business days~~**working days** from receipt of the request for authorization, issue a written decision deferring utilization review of the requested treatment unless the requesting physician has been previously notified under this subdivision of a dispute over liability and an explanation for the deferral of utilization review for a specific course of treatment. The written decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. The written decision shall contain the following information specific to the request:

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to "business days" in the regulations should be changed to "working days" in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.9.3(a) as follows:

(a) The first day in counting any timeframe requirement is the day after the receipt of the request for authorization, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the **information reasonably necessary to make a determination, which shall include but not be limited to a** request for authorization.

Discussion:

The addition of "information reasonably necessary" comports with the statutory language of Labor Code section 4610(i)(3).

Recommendation:

Modify § 9792.9.3(b) as follows:

(b) Prospective or concurrent decisions to approve, modify, ~~delay~~, or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) ~~business days~~**working days** from the date of receipt of the completed request for authorization.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to "business days" in the regulations should be changed to "working days" in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.9.4(b) as follows:

(b) For prospective, concurrent, or expedited review, approvals shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or, if agreed to by the parties, secure electronic mail. If the communication is by telephone, it shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two (2) ~~business days~~ **working days** for prospective review.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to “business days” in the regulations should be changed to “working days” in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.9.5 (c) as follows:

(c) For prospective, concurrent, or expedited review, a decision to modify or deny a request for treatment on the basis of medical necessity shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or, if agreed to by the parties, secure electronic mail. The facsimile or electronic mail shall contain the information set forth in subdivision (e) or (f). If the communication is by telephone, it shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker’s attorney within 24 hours of the decision for concurrent review and within two (2) ~~business days~~ **working days** for prospective review and for expedited review within 72 hours of receipt of the request.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to “business days” in the regulations should be changed to “working days” in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.9.5 (e) as follows:

(e) The written decision modifying or denying treatment authorization, based on medical necessity shall be provided to the requesting physician, the injured worker, the injured worker’s representative, and if the injured worker is represented by counsel, the injured worker’s attorney. The written decision shall be signed by ~~either the claims administrator or~~ the reviewer, and shall contain the following information specific to the request:

Discussion:

Deletion of punctuation is necessary to improve syntax.

In light of the new restriction of this subdivision to instances of medical necessity, the provision allowing a claims administrator to sign the decision should be eliminated. Claims administrators may not modify or deny treatment based on medical necessity.

Recommendation:

Modify § 9792.9.5 (f)(1)(H) as follows:

(3) Either the requesting physician or the injured worker may, within 45 days of the denial, submit the missing information as identified under (f)(1)(E). Upon receipt of the additional information, the process of reconsideration under (f)(1)(G) shall commence.

Discussion:

Following a UR denial based on lack of information, provision should be made for the provider or the injured worker to submit the missing information, and a limitation of 45 days should be imposed for the submission of the additional information.

Recommendation:

re: §9792.9.6 (a) - Extension of Timeframes for Decision

Discussion:

The Institute suggests that consideration be given to the potential for abuse of Expedited RFA. With only 72 hours to issue a determination, the claims administrator faces an insurmountable hurdle when presented with such a request at, say, 5:00 p.m. on a Friday prior to a three-day weekend. Strictly counting 72 hours renders the deadline to expire on a holiday (i.e., neither a working day nor a business day). While the Institute recognizes the “imminent and serious threat” faced by an injured worker in need of treatment, a solution is required for situations where the use of an Expedited RFA is unwarranted.

Recommendation:

Modify § 9792.9.6 (b)(1) as follows:

(b)(1) If the circumstance under subdivision (a)(1)(A) applies, a reviewer or non-physician reviewer shall request the information from the treating physician within five (5) businessdaysworking days from the date of receipt of the request for authorization.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to “business days” in the regulations should be changed to “working days” in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.9.6 (c)(2) as follows:

(2) If any of the circumstances set forth in subdivisions (a)(1)(B) or (C) are deemed to apply following the receipt of a complete or accepted request for authorization, the physician reviewer shall within five (5) ~~business days~~working days from the date of receipt of the request for authorization notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the reviewer cannot make a decision within the required timeframe, and request, as applicable, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to "business days" in the regulations should be changed to "working days" in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.9.6 (d)(1) as follows:

(d)(1) Upon receipt of the information requested pursuant to subdivisions (a)(1) (A), (B), or (C), the claims administrator or reviewer, for prospective or concurrent review, shall make the decision to approve, modify, or deny the request for authorization within five (5) ~~business days~~working days of receipt of the information in accordance with the applicable provisions of sections 9792.9.4 and 9792.9.5.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to "business days" in the regulations should be changed to "working days" in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.9.7(a)(4) as follows:

(4) All treatment or services anticipated to be provided to the injured worker in the first 30 days after the date of injury, including the exempt drugs prescribed to the injured worker under the MTUS Drug Formulary, are set forth in a request for authorization provided to the claims administrator in accordance with section 9785(~~hg~~hg). The form shall be submitted to the claims administrator concurrent with the Doctor's First Report of Occupational Injury or Illness. Subsequent treating physicians during the 30-day period shall submit a request for authorization following their first visit with the injured worker indicating all treatment being rendered.

Discussion:

The correct reference here is to § 9785(g), not (h), due to new renumbering of that section.

This subdivision requires an RFA to be submitted for every treatment request, including fast-track treatment during the first 30 days. If that is the intention of the Division, this language is appropriate. However, if the intention of the fast-track provisions is to provide treatment without encumbrance, then the requirement for submission of an RFA in every instance is inappropriate. An alternative would be to permit provision of fast-track treatment without an RFA unless specifically requested/required by the claims administrator.

Recommendation:

Modify § 9792.9.7(c)(1)(C)(2) as follows:

(2) For the purpose of this section, “pattern and practice” means failing, over a period of ~~six~~ **three** months, to render treatment that is consistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary, with at least **five**~~three~~ injured workers.

Discussion:

A non-complying treating physician may well be providing inappropriate treatment to injured workers across multiple claims administrators. Requiring each claims administrator to meet a threshold of five patients in six months is an inappropriate burden, when injured workers are at risk from harmful treatment.

Recommendation:

Modify § 9792.9.8(b)(1) as follows:

(1) Prospective decisions to approve, modify, or deny a request for authorization for a drug not covered under subdivision (a) of this section shall be made in a timely fashion that is appropriate for the nature of the injured worker’s condition, not to exceed five (5) ~~business days~~**working days** from the date of receipt of a completed or accepted request for authorization. The decision shall be communicated in the manner set forth in sections 9792.9.4 and 9792.9.5.

Modify § 9792.9.8(b)(2)(B) as follows:

(B) If the information is not received within five (5) ~~business days~~**working days** from the date of the request for information, the reviewer shall deny the request in accordance with section 9792.9.5(f).

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to “business days” in the regulations should be changed to “working days” in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.12 (b)(1) as follows:

For failure to comply with the requirement that only a licensed physician may modify or deny, regardless of the reason for denial, requests for authorization of medical treatment to cure or relieve as required under section 4610(g)(3) of the Labor Code, **except as provided for in Labor Code section 4604.5(c):** \$25,000;

Discussion:

It appears that the Division is attempting to remove the claims administrator's ability to enforce the statutory cap of Labor Code section 4604.5(c) by removing this exception language, thereby subjecting a claims administrator to a \$25,000 fine for following a statutory provision. The Institute does not believe the Administrative Director has the authority to negate statute and, therefore, recommends the exception language be kept.

Thank you for the opportunity to comment, and please contact us if additional information would be helpful.

Sincerely,

Denise Niber
Claims and Medical Director

DN/pm

cc: Executive Director, Department of Industrial Relations
George Parisotto, DWC Administrative Director
CWCi Claims Committee
CWCi Medical Care Committee
CWCi Legal Committee
CWCi Regular Members
CWCi Associate Members